CASE INITIATION DOCUMENT

TYPE OF ACTION (CHECK ONE)

_____ Initial Filing

_____ Address Change

_____ Employee/Employer Atty Firm Change

_____ Adjusting Agency Change

INSTRUCTIONS: This form shall be completed and attached to all requests for Rehabilitation Unit action on matters for which no Rehabilitation Unit Case number has been assigned. This form is also to be used to update address changes for any of the parties or to record changes in representation for either the employer or employee and any change of adjusting agency. This form must be typed or printed clearly and submitted to the appropriate Rehabilitation Unit office. See reverse side for Rehabilitation Unit addresses.

EMPLOYEE NAME:	(LAST)	(FIRST)	(M.I.)	SEX:
ADDRESS:	(STREET)	(CITY)	(STATE)	(ZIP)
DATE OF BIRTH:	PHONE #:	SOCIAL SECURITY #:	DATE OF INJURY:	

EMPLOYER NAME: _____ DWC ID # (if known): _____

MAILING ADDRESS (incl. city, state & zip): _____

SELF INSURED CERTIFICATE NAME: _____

INSURANCE CARRIER (if any): _____

ADJUSTING AGENCY NAME (if agency adjusted): _____

CLAIMS MAILING ADDRESS (incl. city, state & zip): _____

PHONE #: _____ CLAIM #: _____

QUALIFIED REHAB REPRESENTATIVE, IF ANY

FIRM NAME: _____ REPRESENTATIVE NAME: _____

MAILING ADDRESS (incl. city, state & zip): _____

PHONE #: _____ DWC FIRM # (if known): _____

EMPLOYEE'S REPRESENTATIVE, IF ANY

FIRM NAME: _____ REPRESENTATIVE NAME: _____

MAILING ADDRESS (incl. city, state & zip): _____

PHONE #: _____ DWC FIRM # (if known): _____

EMPLOYER'S REPRESENTATIVE, IF ANY

FIRM NAME: _____ REPRESENTATIVE NAME: _____

MAILING ADDRESS (incl. city, state & zip): _____

PHONE #: _____ DWC FIRM # (if known): _____

SUBMITTED BY: _____

TITLE: _____

DATE: _____

REHABILITATION UNIT USE ONLY

Must be printed on Goldenrod paper or preapproved computer generated with Goldenrod borders.

Mandatory Format
State of California
DWC Form RU-101 (12/90)

Rehabilitation Unit
California Division of Workers' Compensation

Form RU-101

CASE INITIATION DOCUMENT

Purpose:
To provide identifying data to the Rehabilitation Unit for case make-up, report changes of name or address of the parties on existing cases, or notify the Rehabilitation Unit of representation on existing cases.

Submitted by:
Claims Administrator, employee, and their representatives.

When submitted:
When Rehabilitation Unit action is required and no rehabilitation file exists. To change the name or address, where there is an existing Rehabilitation Unit file, of any party involved.

Where submitted:
With the correct Rehabilitation Unit district office. A venue list is available to help you match the zip code of the residence of the employee with the venues of the district offices. The venue list is available upon request from:

Division of Workers' Compensation
REHABILITATION UNIT HEADQUARTERS
P.O. Box 420603
San Francisco, CA 94142-0603

Form completion:
Type all the required information. All questions must be answered. **Place particular emphasis on entering the following information accurately using ten point type:**

- **Social Security Number:** Enter nine (9) digits.
- **Employer Name:** Enter the full name of the employer and mailing address including city, state, and zip code.
- **Date of Injury:** Enter the full date of injury (month, day and year). Use only one date on this and all other documents submitted to the Rehabilitation Unit. If the injury is a cumulative injury, and if injury is admitted or found, use the date at the end of the cumulative period.

Accompanying documents:
Attach the form requesting Rehabilitation Unit action and all medical and vocational reports required by that form.

Rehabilitation Unit action:
The Rehabilitation Unit assigns a case number and will take appropriate action depending upon the request attached to the Case Initiation Document RB-101.

Copy:
All parties.